

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295068		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2009	
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR-MESQUITE				STREET ADDRESS, CITY, STATE, ZIP CODE 272 PIONEER BLVD MESQUITE, NV 89027			
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F 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of the Medicare complaint investigation conducted at your facility on March 12, 2009. The complaint investigation was conducted under the 42 CFR Chapter IV Part 483- Long Term Care Facilities. The census at the beginning of the survey was 81.</p> <p>The following complaints were investigated.</p> <p>Complaint #NV19850- Substantiated (Tags F281, F309, F425) Complaint #NV19959- Unsubstantiated</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>			F 000			
F 281 SS=D	<p>The following deficiencies were identified.</p> <p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure licensed nursing personnel administered medications in accordance with facility's policies and procedures and with the professional standards of quality set forth in the Nevada State Board of Nursing Nurse Practice Act (Nevada Administrative Code Chapter 632).</p>			F 281			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>Findings include:</p> <p>Nurse Practice Act Nevada Administrative Code Chapter 632</p> <p>632.220 Medication and treatment of patients: response to orders; adjustment of dosage or frequency of medications.</p> <p>1. A registered nurse shall perform or supervise:</p> <p>(a) The verification of an order given for the care of a patient is to ensure that it is appropriate and properly authorized and that there are no documented contraindications in carrying out the order:</p> <p>b) Any act necessary to understand the purpose and effect of medications and treatments and to ensure the competence of the person to whom the administration of medications is delegated to: ...</p> <p>632.224 Supervision of others; duties of chief nurse; determination of authorized scope of practice; verification of competency.</p> <p>2. A registered nurse who is employed as a chief nurse is responsible for the management of other personnel under his supervision and shall:</p> <p>... (e) Create a safe and effective system for the delivery of nursing care which complies with nationally recognized standards.</p> <p>POLICY AND PROCEDURE</p> <p>POLICY NO: 3.17 (NV) AREA: Nursing</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>SUBJECT: Pharmaceutical Procedure</p> <p>Policy:</p> <p>1. It is the policy of the facility to review residents' medication on a regular basis in order to provide residents with only the necessary medications for their health needs.</p> <p>IV. Procurement and Labeling of Drugs</p> <p>D. Medication prescribed for a resident and so labeled shall not be administered to another resident.</p> <p>V. Care and Storage of Medications</p> <p>G. The medications of each resident shall be kept and stored in their originally stored containers. Medication shall not be transferred between containers.</p> <p>Exception to Item G:</p> <p>A licensed nurse may remove medications from original containers and place it in other containers to be sent with a resident when the resident will be out of the facility at the time of scheduled medication administration, as for instance, when the resident is on a home visit or away from the facility for employment, workshop, or school. Such medication shall be labeled by the nurse with the name of the resident, name of the medication, instructions for taking and any other appropriate information.</p> <p>VI. Drug Administration and Documentation</p> <p>Administration of Medications</p> <p>A. All medications shall only be administered by</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>licensed medical or licensing nursing personnel in accordance with their respective licensing requirements. All nursing personnel must have either appropriate training or experience if duties include administering medications to residents.</p> <p>D. The Director of Nursing shall provide on-going supervision of personnel administering medications, including:</p> <ol style="list-style-type: none"> 1. Regular observation of performance in actual preparation and administration. 2. Coordination review of medication records for accuracy and any irregularities. <p>Job Description for the Activity Director (revised: 11/06)</p> <p>2. Activity Director Job Function: Coordinate and supervise all social and recreational activities provided to residents of the facility.</p> <p>Specific Duties:</p> <ol style="list-style-type: none"> 1. Develop Activity calendar. 2. Develop and implement psychosocial groups. 3. Develop and implement behavior programs. 4. Complete Activity Assessment, Geriatric Depression Scale and Elopement Assessment. 5. Orientate and supervise volunteers. 6. Schedule outside activities. <p>Interview</p> <p>On 3/12/09 at 11:30AM, the Director of Nursing indicated the Activity Director was handed the envelope by the licensed nurse with the resident's name and what time the medication/ medications were to be administered. When the resident had a medication at a different time, another envelope was given to the Activity Director.</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>On 3/12/09 in the afternoon, the Activity Director indicated: When residents were on an outing, the former Activity Director administered a resident (Resident #2) another resident's medication. When the Activity Director returned to the facility, the error was identified. The licensed nurse notified the resident's physician and family. The resident was monitored and there were no adverse reactions noted. Subsequently, Employee #2 indicated: the medications were packaged by the licensed nurse and given to the Activities Director and then given to the residents during the outing. The medications were given to the residents twice a week during the outings to the casino and the breakfast club.</p> <p>At the time of the interview, The Director of Nursing was unable to provide documentation of the medication error and a subsequent investigation conducted. On 3/20/08 at 3:25PM, the Director of Nursing faxed the documentation. The medication error was dated 10/21/08. The resident was given Keflex 250 milligrams (mg), Tylenol 650 mg. and Potassium 10 mg. by mouth. The Activity Director did not verify the resident's full name prior to administration of the medications.</p> <p>Registered Nurse #3 documentation dated 9/21/08, stated "My patient was going out on a dinner activity and had some medications that were scheduled during this visit. There is an order stating that the patient may go out on a therapeutic pass with medications. So with this order, I placed the scheduled medications in a medication travel envelope marked with patient's name, date, time to be given, medication name and Doctor's name. Packet was given to activity director to be given to patient at dinner. After the</p>	F 281			

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F 281	<p>Continued From page 5</p> <p>activity group left, I noticed that my patient was still in the building and medication packet was still with the activity director. When she returned I asked her for the medication packet. She reported that she gave it to the patient with the same first name as my patient. Medication error was discussed with Director of Nursing and the other patient's nurse. Error was documented."</p> <p>Registered Nurse #4 undated documentation on the report indicated: "I have been asked to write a brief statement regarding a medication error that had occurred while I was employed as an LPN (licensed practical nurse). I arrived on my shift that night and was informed by the Director of Nursing and LPN that Resident #2 had been given the wrong medication by the Activities Director while she was on an outing provided by the facility. When I was asked what had happened they explained to me that the Activities Director had given the resident medication belongings to another patient that had shared the same first name. The primary physician and family was notified. The resident was monitored during the shift and no adverse reaction were observed.</p> <p>On 3/12/09 at 12:15PM, Resident #1 indicated when residents were out of the facility on an activity, the Activity Director took medications with her and gave the medications to the residents. The medications were put in an envelope with the name and sealed, then the Activity Director gave the medications to the residents at the scheduled times.</p> <p>The Activity Director was not qualified to administer medications to the residents. The facility failed to ensure licensed nurses</p>	F 281			

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F 281	Continued From page 6 administered medications to residents which conflicted with facility policy and the Nurse Practice Act as indicated above.	F 281			
F 309 SS=D	Complaint #NV19850 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure residents received the proper medication. Findings include: Interview On 3/12/09 in the morning, the Director of Nursing indicated: When the residents were on an outing, the Director of Activities administered a resident (Resident #2) another resident's medication. The Activity Director returned to the facility and an error was identified. The licensed nurse notified the resident's physician and family. The resident was monitored, there were no adverse reactions noted. At the time of the interview, Employee #1 was unable to provide documentation of the medication and the investigation conducted.	F 309			

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F 309	<p>Continued From page 7</p> <p>On 3/20/08 at 3:25PM, Employee #1 faxed the documentation. The medication error was dated 10/21/08. The resident was given Keflex 250 milligrams (mg), Tylenol 650 mg. and Potassium 10 mg. by mouth. The Activity Director did not verify resident's full name prior to administration of the medications.</p> <p>On 3/13/09 the Director of Nursing faxed documentation which stated: "On 10/21/08, I was informed that a former Activity Director had made a med error while she was with residents on a dinner outing. The Activity Director informed me that she did not read the medication envelope completely and had given Resident #1 another resident's envelope. Residents share the same first name. I immediately asked the nurse on shift to contact the resident's primary care physician and her family to inform them and follow-up. The resident's drug allergies were reviewed. The resident was not allergic to any medication she had taken. I spoke with Activity Director regarding possible consequences due to medication error and ways to ensure this error did not occur again. Follow-up verbally in a.m. with on shift nurse to ensure a resident had been monitored. I spoke with resident who stated, she was feeling well and had a good night. "</p> <p>On 3/12/09 in the afternoon, Employee #2 indicated: the medications were packaged by the licensed nurse and given to the Activities Director and then given to the residents during the outing. The medications were given to the residents twice a week during the outings to the casino and the breakfast club.</p> <p>The Activity Director was not qualified to</p>	F 309			

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F 309	Continued From page 8 administer medications to the residents. The facility failed to ensure the resident was administered the proper medications in accordance with the plan of care by a licensed nurse.	F 309			
F 425 SS=D	Complaint #NV19850 483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the accurate dispensing and administering of all drugs to residents. Findings include:	F 425			

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F 425	<p>Continued From page 9</p> <p>POLICY AND PROCEDURE</p> <p>POLICY NO: 3.17 (NV) (Revised 12/06)</p> <p>AREA: Nursing</p> <p>SUBJECT: Pharmaceutical Procedure</p> <p>Policy:</p> <p>1. It is the policy of the facility to review residents' medication on a regular basis in order to provide residents with only the necessary medications for their health needs.</p> <p>Purposes:</p> <p>1. To provide the appropriate control of procurement, distribution, administration and utilization of drugs to the facility.</p> <p>2. To provide the facility residents with the safest, effective and most rational form of drug therapy at a reasonable cost.</p> <p>3. To serve as the primary resource of drug information and education to professional personnel in providing quality pharmacotherapy to the facility.</p> <p>Staff responsibility:</p> <p>1. Director of Nursing</p> <p>2. Staff Nurses</p> <p>3. Physician</p> <p>4. Pharmacist</p> <p>5. Administrator</p> <p>IV. Procurement and Labeling of Drugs</p> <p>D. Medication prescribed for a resident and so labeled shall not be administered to another resident.</p> <p>V. Care and Storage of Medications</p>	F 425			

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F 425	<p>Continued From page 10</p> <p>G. The medications of each resident shall be kept and stored in their originally received container. Medication shall not be transferred between containers.</p> <p>Exception to Item G:</p> <p>A licensed nurse may remove medications from original containers and place it in other containers to be sent with a resident when the resident will be out of the facility at the time of scheduled medication administration, as for instance, when the resident is on a home visit or away from the facility for employment, workshop, or school. Such medication shall be labeled by the nurse with the name of the resident, name of the medication, instructions for taking and any other appropriate information.</p> <p>VI. Drug Administration and Documentation Administration of Medications</p> <p>A. All medications shall only be administered by licensed medical or licensing nursing personnel in accordance with their respective licensing requirements. All nursing personnel must have either appropriate training or experience if duties include administering medications to residents.</p> <p>D. The Director of Nursing shall provide on-going supervision of personnel administering medications, including:</p> <ol style="list-style-type: none"> 1. Regular observation of performance in actual preparation and administration. 2. Coordination review of medication records for accuracy and any irregularities. <p>N. For all medications released to discharged</p>	F 425			

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F 425	<p>Continued From page 11</p> <p>residents or released for home visit or workshop use, the responsible party must sign a statement taking full responsibility for medication handling.</p> <p>2. Home Visit Medications</p> <p>Plastic "baggies" or envelopes are available for nurse repacking for short-term home visits. These bags should be used for typical weekend home visits. The nurse should fill out the front section with the appropriate information. Liquids, ointments, injectables, etc. may be either released from the resident's own supply or may be requested from the pharmacy.</p> <p>3. Workshop Medications</p> <p>Workshop medications will be delivered to the facility or to the workshop. A month's supply of workshop medications will be sent by the pharmacy to the workshop in properly- labeled containers. The facility will be responsible for notifying the workshop of new doses, discontinued doses, or changes in doses of workshop medications. It is the responsibility of the workshop to notify either the facility or pharmacy when medications need to be refilled for workshop use.</p> <p>Medication Errors and Adverse Reactions</p> <p>A. Medication Errors</p> <p>Defined: Medication errors are defined as:</p> <ol style="list-style-type: none"> a. Wrong drug administered 2. Wrong dose administered 3. Administered to the wrong resident 4. Wrong dosage form 5. Wrong time 6. Not given per manufacturer's specifications and with standards of practice. 	F 425			

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F 425	<p>Continued From page 12</p> <p>7. Medication given past specified stop date</p> <p>8. Scheduled medication omitted for no apparent reason (if not given for justifiable reason, e.g. drug not currently available, pharmacy delivery has not arrived, resident out of the facility, omission shall be documented but not considered an error.)</p> <p>Medication errors should be reported to the resident's physician as soon as possible.</p> <p>Nurse Practice Act Nevada Administrative Code Chapter 632</p> <p>632.220 Medication and treatment of patients: response to orders; adjustment of dosage or frequency of medications.</p> <p>1. A registered nurse shall perform or supervise:</p> <p>(a) The verification of an order given for the care of a patient is to ensure that it is appropriate and properly authorized and that there are no documented contraindications in carrying out the order:</p> <p>b) Any act necessary to understand the purpose and effect of medications and treatments and to ensure the competence of the person to whom the administration of medications is delegated to: ...</p> <p>632.224 Supervision of others; duties of chief nurse; determination of authorized scope of practice; verification of competency.</p> <p>2. A registered nurse who is employed as a chief nurse is responsible for the management of other</p>	F 425			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2009
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR-MESQUITE			STREET ADDRESS, CITY, STATE, ZIP CODE 272 PIONEER BLVD MESQUITE, NV 89027		
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F 425	<p>Continued From page 13</p> <p>personnel under his supervision and shall:</p> <p>... (e) Create a safe and effective system for the delivery of nursing care which complies with nationally recognized standards.</p> <p>Job Description for the Activity Director (revised: 11/06)</p> <p>Job Function: Coordinate and supervise all social and recreational activities provided to residents of the facility.</p> <p>Specific Duties:</p> <ol style="list-style-type: none"> 1. Develop Activity calendar. 2. Develop and implement psychosocial groups. 3. Develop and implement behavior programs. 4. Complete Activity Assessment, Geriatric Depression Scale and Elopement Assessment. 5. Orientate and supervise volunteers. 6. Schedule outside activities. <p>Interview</p> <p>On 3/12/09 at 11:30AM, the Director of Nursing indicated: When the residents were on an outing, the Director of Activities administered a resident (Resident #2) another resident's medication. When the Activity Director returned to the facility, the error was identified. The licensed nurse notified the resident's physician and family. The resident was monitored. There were no adverse reactions noted.</p> <p>On 3/12/09 at 12:15PM, an interview with Resident #1 was conducted. The resident indicated when the residents were out of the facility on an activity, the Activity Director took medications with her and gave the medications</p>	F 425			

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F 425	<p>Continued From page 14</p> <p>to the residents. The medications were put in an envelope with the name and sealed, then the Activity Director gave the medications to the residents at the scheduled times. This happens when the residents do not receive their medications before the outing.</p> <p>On 3/12/09 in the afternoon, Employee #2 indicated: the medications were packaged by the licensed nurse and given to the Activities Director and then given to the residents during the outing. The medications were given to the residents twice a week during the outings to the casino and the breakfast club.</p> <p>The licensed nurse did not have the authority to transfer medication from the original container to an envelope for the Activity Director to give to the resident during an activity outing.</p> <p>The Activity Director was not qualified to administer medications to the residents. The facility's drug administration policy and procedure indicated that all medications shall only be administered by licensed medical or licensing nursing personnel in accordance with their respective licensing requirements. The facility failed to ensure medications were not dispensed by the licensed nurse and transferred to another container for the Activity Director to administer to a resident on an outing.</p> <p>Complaint #NV19850</p>	F 425			